,

2017 Performance Improvement Report

STRATEGIC PRIORITY

 2. Increase capacity and patient access

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| **Project Name** |
| Increase The Number of Discharged Palliative Patients Under Home Health Care From 58% To 70%, By The End of Q3 2017 |
| **Site** | **Department** |
| Jeddah | Oncology Department / Palliative Medicine Section |
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| **Project Status** | **Project Start Date** | **Project End Date**  |
| Completed | 01-01-2017 | 09-01-2018 |

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| **Problem:** Why the project was needed?Palliative HHC (Home Health Care) provides medical care and support services to a patient with a terminal illness where the focus is on quality of life rather than life prolongation or cure. Palliative HHC is one of interdisciplinary team care that provides comprehensive care by addressing the physical, psychological, social, and spiritual aspects of suffering. | **Aims:** What will the project achieve?Help patients achieve comfort and quality of life until death with dignity: the care and treatment provided are based on the patient's and family’s goals and values. |
| **Benefits/Impact:** What is the improvement outcome?*(check all that apply)*[x]  Contained or reduced costs[x]  Improved productivity[x]  Improved work process[x]  Improved cycle time[x]  Increased customer satisfaction[ ]  Other (please explain) Click or tap here to enter text. | **Quality Domain:** Which of the domains of healthcare quality does this project support?*(Select only one)***Efficient** |

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| **Measures:** Performance metrics to be evaluated | **Targets:** Expected outcomes |
| Number of discharged palliative patients | Increase percentage of patients discharge under Home Health Care from 58% to 70% by the end of 3rd quarter 2017 |

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| **Interventions:** Overview of key steps/work completed* Frequent multidisciplinary meetings with the patient and family with full orientation about Home Health Care and the service could be offered to the patient at home, and also the advantages for the patient to be at home
* Social Service counseling
* Home Health Care team consultation
* Establish frequent nursing visits at home
* Establish frequent physician visits at home
* Palliative Clinical Coordinator visits, and open phone service answering patients and their families about any concerns
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| **Results:** Insert relevant graphs and charts to illustrate improvement pre and post project*(insert relevant graphs, data, charts, etc.)* |

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| **Project Lead** | **Team Members** |
| **Name** *(person accountable for project)* | **Names***(persons involved in project)* |
| Belal Sharaf | Mohd. AnsariHusna MunsoorNuha AliNawal El AmirAmani SindiSarbonza Meera |